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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **ELAINE ORTALEZA MEGIA** **91 Renwood Lane** **American Canyon, California 94503** **Registered Nurse Number 722590** Respondent.	Case Number 2013-37 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Complainant Louise R. Bailey, M.Ed., R.N., brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing (Board), Department of Consumer Affairs.

2. On or about March 12, 2008, the Board issued Registered Nurse License Number 722590 to Respondent Elaine Ortaleza Megia. This Registered Nurse license was in full force and effect at all times relevant to the charges brought in this Accusation and will expire on October 31, 2013, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 118, subdivision (b), provides:

"The suspension, expiration, or forfeiture by operation of law of a license issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the board or by order of a court of law, or its surrender without the written consent of the board, shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute of continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the licensee on any such ground."

5. Section 2750 provides:

"Every certificate holder or licensee, including licensees holding temporary licenses, or licensees holding licenses placed in an inactive status, may be disciplined as provided in this article [Article 3 of the Nursing Practice Act (Bus. & Prof. Code, § 2700 et seq.)]. As used in this article, 'license' includes certificate, registration, or any other authorization to engage in practice regulated by this chapter. The proceedings under this article shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code [the Administrative Procedure Act], and the board shall have all the powers granted therein."

6. Section 2764 provides:

"The lapsing or suspension of a license by operation of law or by order or decision of the board or a court of law, or the voluntary surrender of a license by a licentiate shall not deprive the board of jurisdiction to proceed with any investigation of or action or disciplinary proceeding against such license, or to render a decision suspending or revoking such license."

STATUTORY PROVISIONS

7. Section 2761 provides, in pertinent part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

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"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

8. California Code of Regulations, title 16, section 1442, provides:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

9. California Code of Regulations, title 16, section 1443, provides:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

COST RECOVERY

10. Section 125.3, subdivision (a), provides:

"Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board upon request of the entity bringing the proceedings, the administrative law judge may direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case."

FACTUAL BACKGROUND

11. On or about April 7, 2010, Patient A was transferred from Atascadero State Hospital, where he had a record of suicide attempts and self-injurious behavior, to Napa State Hospital in Napa, California. Patient A was admitted to the inpatient psychiatric unit.

12. On or about April 9, 2010, Patient A tried to wrap a bedsheet around his neck while in five-point restraints. A suicide risk assessment made that day indicated Patient A was a moderate risk for suicide.

13. On or about April 10, 2010, Respondent was assigned as Patient A's treatment

nurse.

14. At about 7:45 a.m., Patient A again was placed in five-point restraints for being combative. He was released from restraints at about 10:00 a.m.

15. At about 10:30 a.m. on the same day, Patient A was placed in a room which had restraint belts on a bed. Staff was to remove these belts because they presented a suicide risk.

16. After being released to his own room at about 11:35 a.m., Patient A was found with one of the restraint belts over his shoulder. He surrendered the belt to staff.

17. At about 11:40 a.m., staff found Patient A under his bed with another belt wrapped around his neck. He was breathing, but his face was bluish in color.

18. Hospital police officers transferred Patient A to a treatment room. Respondent was directed by her supervisor to assess Patient A. One of the officers told Respondent that Patient A was found under his bed with a belt around his neck. Respondent checked Patient A's vital signs. Records indicate that Patient A then was placed on close and constant observations at about 11:45 a.m.

19. During the next two days, Patient A made efforts to kill himself three more times and was placed in five-point restraints once.

20. Respondent, who was assigned as Patient A's treatment nurse, did not familiarize herself with Patient A's history. She did not perform a suicide assessment on Patient A. She did not notify the medical officer of the day that Patient A had tried to commit suicide. She did not complete the required mandated report for suspected abuse. She did not document the incident in a medical record or incident report. She did not constantly observe Patient A after he was found under the bed with the belt wrapped around his neck, and left him unattended for periods of time. She allowed an unlicensed staff member to relieve her from her observation duties.

21. Respondent was interviewed twice. During those interviews, she stated that she did not perform a suicide evaluation on Patient A because she did not have time. She admitted that she did not notify the medical officer of the day that Patient A had tried to commit suicide.

22. On or about October 14, 2010, Respondent was disciplined by the California Department of Mental Health in the form of a one-step salary reduction for 12 months effective

beginning November 10, 2010.

FIRST CAUSE FOR DISCIPLINE
Unprofessional Conduct: Gross Negligence
(Bus. & Prof. Code, §§ 2761, subds. (a) & (a)(1))

22. The allegations of paragraphs 11-22 are realleged and incorporated by reference as if fully set forth.

23. Respondent has subjected his license to disciplinary action for unprofessional conduct under section 2761, subdivision (a), as defined by subdivision (a)(1) (gross negligence) and California Code of Regulations, title 16, section 1442. As set forth in paragraphs 17-21 above, Respondent was grossly negligent and manifested an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse by acts which include, but are not limited to, the following: not familiarizing herself with Patient A's history, not performing a suicide assessment on Patient A, not notifying the medical officer of the day that Patient A had tried to commit suicide, not completing the required mandated report for suspected abuse, not documenting Patient A's suicide attempt in a medical record or incident report, not constantly observing Patient A after his attempted suicide and leaving him unattended for periods of time, and allowing an unlicensed staff member to relieve her from her observation duties.

SECOND CAUSE FOR DISCIPLINE
Unprofessional Conduct: Incompetence
(Bus. & Prof. Code, § 2761, subds. (a) & (a)(1))

24. The allegations of paragraphs 11-22 are realleged and incorporated by reference as if fully set forth.

25. Respondent has subjected her license to disciplinary action for the unprofessional conduct under section 2761, subdivision (a), as defined by subdivision (a)(1) (incompetence) and California Code of Regulations, title 16, section 1443. As set forth in paragraphs 17-21 above, Respondent was incompetent and failed to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse by acts which include, but are not limited to, the following: not familiarizing herself with Patient A's history, not performing a suicide assessment on Patient A, not notifying the medical officer of the day that

Patient A had tried to commit suicide, not completing the required mandated report for suspected abuse, not documenting Patient A's suicide attempt in a medical record or incident report, not constantly observing Patient A after his attempted suicide and leaving him unattended for periods of time, and allowing an unlicensed staff member to relieve her from her observation duties.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board issue a decision:

1. Revoking or suspending Registered Nurse License Number 722590, issued to Elaine Ortaleza Megia;

2. Ordering Elaine Ortaleza Megia to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case pursuant to Business and Professions Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: July 13, 2012

LOUISE R. BAILEY, M.Ed., R.N.
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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